



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

WEST TEXAS REHAB CENTER

**Respondent Name**

STATE OFFICE OF RISK MANAGEMENT

**MFDR Tracking Number**

M4-18-0285-01

**Carrier's Austin Representative**

Box Number 45

**MFDR Date Received**

OCTOBER 3, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Faxed original claim with documentation to SORM on 2/15/17. 6/7/17 Called SORM and was told that there was no claim on file. Refaxed with original confirmation sheet...This claim was filed in a timely manner as can be seen by fax confirmation sheets. This was a clean claim and should be paid."

**Amount in Dispute:** \$1,200.03

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Office researched the fax confirmations submitted by the requestor to find the initial fax confirmation does not show evidence of the fax number is was sent to. The fax submitted on 7/31/2017 does show it was faxed to 512-370-9025...The Office received an initial medical bill on 6/7/2017 for date of service 2/9/2017, a denial for 29-Time limit for filing has expired was issued on 7/17/2017."

**Response Submitted by:** SORM

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2017	CPT Code 97750-FC	\$1,200.00	\$0.00
	G8984 FC, CI (X3)	\$0.03	\$0.00
TOTAL		\$1,200.03	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.

2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. The services in dispute were reduced / denied by the respondent with the following reason codes:
  - 29-The time limit for filing has expired.
  - 107-Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
  - 246-This procedure is inappropriately billed. It should only be billed in conjunction with appropriate required code.
  - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.

### **Issues**

Did the requestor support position that the disputed bills were submitted timely?

### **Findings**

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing has expired." The respondent contends that reimbursement is not due because "The Office researched the fax confirmations submitted by the requestor to find the initial fax confirmation does not show evidence of the fax number is was sent to. The fax submitted on 7/31/2017 does show it was faxed to 512-370-9025...The Office received an initial medical bill on 6/7/2017."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The requestor states "Faxed original claim with documentation to SORM on 2/15/17. 6/7/17 Called SORM and was told that there was no claim on file. Refaxed with original confirmation sheet...This claim was filed in a timely manner as can be seen by fax confirmation sheets. This was a clean claim and should be paid." In support of the requestor's position, the requestor submitted copies of the two Transmission Reports that indicate the following:

- February 15, 2017 that indicates claim was faxed but it does not list the fax number.
- July 31, 2017 that indicates claim was faxed to (512)370-9025.

The division finds the requestor did not support the fax sent on February 15, 2017 was sent to the respondent. Therefore, the requestor did not support the bill was sent within the 95 day deadline. As a result, reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	11/1/2017
Signature	Medical Fee Dispute Resolution Officer	Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**